

Editorial

Children, Youth, and Families: Building on the Cultural Strengths of Hispanic and Latino Communities

Although we have an emotional commitment to improving the welfare of children, we have morbidity and mortality statistics that call into question the level of that commitment. More than 20% of children in the United States live in poverty, and millions do not have access to basic medical care. Approximately one third of all children are either unserved or underserved. Infant mortality is as high as 11% in some communities. Among certain groups of minority youth, death from homicide approaches 160 per 100,000.¹

Although we tend to distinguish the statistical differences between ethnic groups, we should be aware of the substantial variations within these groups as well. For example, the Hispanic Health and Nutrition Examination Survey of 1982–1984 (HHANES) reports varying prevalences of medical, behavioral, and developmental disorders among different Hispanic or Latino groups. According to this survey, Puerto Rican children have a higher prevalence of asthma than Mexican American or Cuban American children. Mexican American and Cuban American children have higher birth weights than Puerto Rican children.² Thus, given the variations among populations, minorities should not be grouped into a single category for statistical purposes.

As a socially and culturally diverse nation, we face a major challenge: we must develop effective health-promoting strategies that address both the common etiologies of morbidity and unique, culturally specific, behaviors.

Representatives of diverse cultural groups, academicians, advocates, public officials, parents, and other professionals convened at Wingspread in Racine, Wisconsin, from June 28 to June 30, 1996. The Johnson Foundation, the Center for Children with Chronic Illness and Disability, and the University of Minnesota's Institute for Health and Disability in the Division of General Pediatrics and Adolescent Health jointly sponsored the meeting. The goal of *Children, Youth and Families: Building on Cultural Strengths of Hispanic and Latino Communities* was to exchange ideas about how to increase the cultural competence of health care professionals who serve children and youths with chronic conditions and how to improve the quality of the services provided to them. Several papers focusing on the assessment of health status, the impact of elevated asthma morbidity among Puerto Rican children, and the ethical and cultural considerations in working with diverse ethnic groups were commissioned.

Traditional health models hold that poverty is the major determinant of negative health outcomes. In *Latino*

Children's Health and the Family-Community Health Promotion Model, Mendoza and Fuentes-Afflick³ state that in most health models, poverty also impacts health status through environmental and behavioral factors. Starfield⁴ found that poor children have morbidity rates for chronic and disabling conditions two to three times higher than those of non-poor children. Race and ethnicity are considered covariants in the relationship between poverty and health. Although we often focus on the negative effects of economically depressed environments, resiliency research has "shown that some aspects of the social-environmental milieu may serve as a buffer against the negative effects of poverty." Mendoza and Fuentes-Afflick present a compelling proposal that challenges traditional health models and invites the reader to consider a new health model, one which incorporates both the medical and public health perspectives.³

Mendoza and Fuentes-Afflick postulate that health care professionals should place greater emphasis on the interrelationships between individuals and the family-community complex, as opposed to the genetic-behavioral-environmental triad accentuated by more traditional health models. They explain that families have the capacity to support the beneficial health behaviors of their members and to make effective use of the natural supports found in their immediate communities. Mendoza and Fuentes-Afflick propose that health status should be assessed from a perspective that considers physical and psychological health, factors that contribute to understanding an individual's functional status, in addition to social and environmental conditions.

In a detailed review of the literature on Hispanic youths with asthma, Lara and colleagues⁵ report that asthma occurs in 11.2% of mainland Puerto Rican children, 2.7% of Mexican American children, 5.9% of non-Hispanic, black children and 5.2% of Cuban American children. Other genetic and biologic risk factors include possible differences in inflammatory responses, differences in airway size, premature birth, and low birth weight. Lara and colleagues also mention socioenvironmental factors as possible factors in the development and expression of the disease. They present access to health as a major problem for Latino children and their families. Barriers to access included language, cultural issues, difficulty obtaining follow-up appointments, and the inability to see a primary care physician.

Lara and colleagues' paper raises provocative questions about research and policy, questions that should trigger the interest of investigators, academicians, and public health activists and compel them to explore the risk and prognostic factors that influence diverse ethnic groups.

In summary, these two papers challenge current methods for measuring health status and propose an alternative health promotion model, one that takes into account the individual's, family's, and community's perceptions

and interpretations of health status or quality of life. Research questions are posed to instigate further investigation of the influence that ethnicity and culture have on health status and health care policy development.

Many recommendations emerged from the conference dialogues around these papers. They addressed service delivery and systems issues; training of professionals, families, and policy makers; and research. Highlights of these recommendations appear below:

There is a need to emphasize multidisciplinary and collaborative strategies in improving systems of care and service delivery. This includes participation in planning, organizing, and delivering services by families, community institutions (health services, education, and social services) and voluntary community associations (churches, neighborhoods, and peer networks). It also includes a focus on the safety of the physical environment in which families live so that risks can be reduced. This process will improve the understanding of the health care needs of these populations.

There is a need in training and practice to focus on understanding unique family strengths and what they contribute to a family's well-being. Understanding the influence of socioenvironmental and cultural factors on a family's health beliefs and practices, organization, and patterns for accomplishing roles will provide practitioners with improved understanding about the family's expectations and level of parental knowledge and experience. With this knowledge, practitioners can more ably tailor treatment decisions to foster best outcomes.

There is a need to conduct research using multiple methods (interviews, videotapes, self-report, participant

observation) grounded in the real lives of families that emphasize the different stages of family development (immigrant or first generation, living in rural or urban environments, primary language), with a focus on children with chronic conditions. This research will provide information to increase understanding about developmental pathways and the effects of chronic stressors such as poverty and violence; it will also lead to improved service delivery.

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